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September 22, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans [CMS-6074-NC]

Dear Acting Administrator Slavitt,

The National Kidney Foundation (NKF) appreciates the opportunity to respond to the "Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans," NKF is concerned about allegations of dialysis patients potentially being steered into health insurance options that primarily benefit the provider or the insurer; but may not necessarily be in the best interests of the patient. However, we note concern that the Request For Information (RFI) does not also call attention to the actions of insurers we have seen and reported to HHS and CMS over the past few years. We firmly agree with CMS that "Enrollment decisions should be made, without influence, by the individual based on their specific circumstances, and health and financial needs." Actions taken by providers and insurers to intentionally steer patients into one type of coverage over another should be stopped. However, restricting patient access to non-profit charities that provide premium assistance to support patients' choice of insurance is not the solution.

NKF is America's largest and long-established health organization dedicated to the awareness, prevention, and treatment of kidney disease for hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of people at risk. While NKF does not provide premium assistance to help kidney patients pay for health insurance coverage nor do we counsel patients on the type of coverage they should choose, we do provide factual information and tools to help patients learn about their options and make informed decisions that best serve their unique needs. We also provide education and resources to kidney health care professionals about health insurance options for ESRD patients. In response to this RFI and to provide a better understanding to CMS of how patients make choices about their insurance we conducted a structured patient survey (Appendix II) and spoke with patients and dialysis and transplant social workers. Our comments to this RFI reflect our findings from that survey and those conversations.

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ESRD Patients Options for Insurance Coverage

It is the understanding of NKF that patients do, and our belief that they should, have the option to enroll in Marketplace coverage if that is the decision the patient believes is best for his or her health and financial well-being. Passage of the Medicare ESRD program in 1972 was a lifesaving change in health policy for Americans with permanent kidney failure. Prior to the benefit most people with kidney failure died having never received dialysis treatment. For those who are eligible, Medicare continues to be the coverage that most ESRD patients choose today. For most patients with private group health plans, the group health plan remains their primary coverage for the first 30 months of Medicare eligibility due to Medicare Secondary Payer (MSP) rules. Once the 30 month Coordination of Benefits (COB) window closes, Medicare becomes primary and the group health plan secondary.[1] However, ESRD patients are not required to enroll in Medicare. Medicare benefits begin upon enrollment.[2]

The MSP policy for a guaranteed 30 month coordination of benefits period, where private insurance remains primary for ESRD patients, only applies to group health plans. For patients with individual health plans (to include Marketplace plans not sold through the Small Business Health Insurance Options Program) who enroll in Medicare, Medicare is primary the day their Medicare coverage begins.[3] Some individual health plans do not pay out benefits secondary to Medicare. Prior to the Affordable Care Act (ACA), very few patients could even enroll in individual health plans if they had ESRD because of pre-existing condition exclusions. CMS has indicated that people who are under 65, not receiving disability benefits, and are enrolled in Marketplace coverage may maintain that coverage. This option is available even if they are diagnosed with ESRD. Patients can also forgo enrollment in Medicare or drop Medicare, if they pay back any benefits paid out, and enroll in Marketplace coverage and still be eligible for tax credits and subsidies.[4] The Internal Revenue Service (IRS) has also indicated that ESRD patients are not excluded from eligibility for subsidies and tax credits to reduce their premiums and out-of-pocket costs for Marketplace coverage.[5] In addition, kidney transplantation and dialysis are essential health benefits and the ACA risk adjustment model includes ESRD to help offset the added costs that health plans will have related to the care of ESRD patients. Selecting benchmark plans and providing risk adjustment payments are policy decisions that were designed to protect high cost patients with special needs from discrimination via denying benefits or attempting to exclude them from coverage as well as to help insurers balance their risk pools to be able to afford to serve high cost patients.

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[1] Medicare Secondary Payer Manual, Ch. 1, Section 10.1 (Rev. 87, 08-03-12)
[2] Sec. 226A of the Social Security Act; 42 U.S.C. 426-1; 42 C.F.R. § 406.13(c).
[3] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html. For ESRD patients who enroll in Medicare, coverage generally starts after three months of receiving in-center hemodialysis. For home dialysis patients Medicare coverage starts during the first month they start dialysis and for transplant recipients Medicare coverage begins the date they are admitted to the hospital to receive a kidney transplant.
[4] Frequently Asked Questions Regarding Medicare and the Marketplace August 1, 2014, updated April 28, 2016.
[5] IRS Notice 2013-41 issued June 2013.

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When it comes to public options, ESRD patients do not have the same rights as Americans over the age of 65 to pick among all of the options. Access to Medigap plans is not federally mandated across all states as it is for people 65 and older. There are 23 states that do not require insurers to offer Medigap plans to ESRD patients under age 65. In some of the states that do require Medigap access ESRD patients are permitted to be charged higher premiums, making it unaffordable for many. Additionally, in those states that do offer Medigap plans, the types of plans available to ESRD patients may be restricted, which limits the benefits they could otherwise get from another type of plan. In addition, dialysis patients are excluded from enrolling in Medicare Advantage (MA) plans, which is the only Medicare coverage that has caps on out-of-pocket expenses for beneficiaries. If a dialysis patient was already enrolled in MA before progressing to ESRD or was receiving retiree benefits under an MA plan they can be grandfathered into that plan (but will not be able to switch to another plan).

Patients who are not eligible under their state's Medicaid program or for the Medicare Savings Program and who enroll in Medicare without access to secondary coverage are subject to paying Medicare premiums and deductibles in addition to a 20% coinsurance under Medicare Part B for each dialysis treatment, out-patient office visit, testing, outpatient procedures, immunosuppressive medications, and non-ESRD related injectable medications. This is in addition to the premium and out-of-pocket costs they incur for prescription drug coverage under Medicare Part D. On average a dialysis patient can incur approximately $7,000 or more annually in out-of-pocket expenses just on coinsurance alone for dialysis.[6]

The United States Renal Database (USRDS) Annual Data Report (ADR) provides data on the types of primary insurance ESRD patients have. Among ESRD patients alive as of December 31, 2013, 37% had Medicare Fee-for-service as their primary coverage and 25% of patients had both Medicare and Medicaid. In addition, 12% of ESRD patients were enrolled in Medicare Advantage plans, 6.5% of patients had Medicare secondary to an employer group health plan and less than 2% had Medicare secondary to an individual health plan. This shows that 82% of ESRD patients were enrolled in Medicare coverage. Data on ESRD enrollment in Marketplace plans is unavailable, but 17% of ESRD patients are not enrolled in Medicare and instead receive "other coverage" to include, coverage by the Department of Veterans Affairs, Indian health Services, Medicaid only, and private individual coverage – including Marketplace plans. In comparing the most recent report to last year's report we note there was little change from 2012 to 2013 in the type of insurance coverage ESRD patients had at the end of each year, but a slight increase in Medicare Advantage coverage and a slight decrease in "other coverage." [7]

While most dialysis patients choose Medicare and/or Medicaid as their coverage there are many reasons for which a patient may prefer private insurance coverage, including Marketplace coverage. Examples of these reasons are:

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[6] Methodology: Assumes Medicare reimbursement rate of $230.39 per dialysis treatment (2016 final unadjusted base rate) and that the patient receives 156 treatments per year in an out-patient dialysis facility.

[7] USRDS

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- the inability to obtain or afford a Medigap policy in their state
- lower costs of private coverage because of caps on out-of-pocket expenses for combined medical services and prescription drugs and the ability to benefit from family coverage and family caps
- access to practitioners that do not accept Medicare or Medicaid (including many mental health practitioners)

In our survey we identified some patients who indicated they were worse off because they had to also enroll in Medicare when they already have private health insurance through their or their spouses' employers and were paying premiums for both types of coverage.

Choosing coverage that results in the least amount of out-of-pocket expenses, but is the most comprehensive to meet individual patient needs, is not easy for anyone to navigate. It is most critical for people with ESRD (who often have multiple co-morbid conditions and who may need dialysis and/or desire a transplant) to understand the options available to them and the pros and cons of those options. Fortunately, ESRD patients have access to dialysis and transplant social workers and financial counselors to help inform and assist them. Social workers serve a critical role in helping patients navigate and apply for public and private assistance including health insurance, Social Security disability, and public and charitable financial assistance. However, Nephrology social workers are not insurance counselors and the time it takes them to navigate insurance options and assist patients in applying for coverage takes away from their current responsibilities. Yet, many social workers do serve in this role because patients may have no other person available to them that understand their unique health care needs and the intricacies of their health insurance options and the regulations that govern those options. Individuals providing counseling to patients need to understand patients' healthcare needs, their healthcare goals (i.e. getting a kidney transplant) and how the each insurance option may affect their access to care. This includes, but should not be limited to, the implications of forgoing or delaying enrollment in Medicare. Given the complexity of information around insurance options and ESRD patients we have recognized there is a need for additional training and education for those that are counseling patients.

For example, patients should be made aware that if they enroll in Medicare Part A, but delay enrollment in Part B or D, and later decide to enroll, they may face late enrollment penalties. If ESRD patients initially enroll only in Part A they cannot later enroll in Medicare Part B until a general enrollment period, which may result in a gap in coverage. ESRD patients who are in a group health plan can delay enrollment in both Part A and Part B during their 30-month coordination of benefit period without any late enrollment penalty.[8,9] However, it is unclear if CMS is applying this same policy to ESRD patients enrolled in individual plans, including Marketplace plans. CMS should clarify in policy and guidance documents the applicability of the late enrollment penalty to ESRD patients enrolled in individual plans, including Marketplace plans. NKF agrees that patients should also be informed that if they forgo Medicare coverage and receive a transplant that their immunosuppressive drugs will be covered under Part D rather

[8] SSA Program Operations Manual - HI 00801.247 Medicare as Secondary Payer of ESRD Benefits https://secure.ssa.gov/poms.nsf/lnx/0600801247.
[9] https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf

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than Part B when they eventually enroll in Medicare. This may cause patients to pay more for their immunosuppressive drugs than they otherwise would. Additionally, in the states that offer Medigap plans to individuals with ESRD, they may not be eligible for Medigap if they delay enrollment because some states only permit enrollment in Medigap for up to 63 days after the individual becomes eligible for Medicare. Similarly, patients should be aware of all of their options for private health insurance coverage and the pros and cons of the different types of plans available to them. The National Kidney Foundation has in the past and will continue to improve educational tools and organize accredited continuing education courses on insurance options to provide unbiased, independent learning opportunities for ESRD patients and the healthcare professionals that assist them.

Charitable Third-Party Premium Assistance and Dialysis Patients

As we stated the NKF does not provide insurance premium assistance. The American Kidney Fund (AKF) Health Insurance Premium Program (HIPP) has afforded many dialysis patients the opportunity to choose among the various current health insurance options available to them which has made their overall healthcare more affordable. Each year the AKF HIPP program assists tens of thousands of dialysis patients who would otherwise not be able to afford the comprehensive health insurance coverage they require. For patients who qualify, the program pays the insurance premiums for any private or public insurance option that a dialysis patient chooses. If a patient receives a transplant during the plan year, AKF pays the premiums through the payment period, but the patient with a successful transplant would not be eligible for the premium assistance after the payment period ends. The program is available to dialysis patients on a first-come-first serve basis and who meet AKF's financial criteria, regardless as to whether or not their healthcare provider contributes to AKF. However, in order to ensure that an applicant is receiving dialysis, the dialysis provider must register for an account in order to submit applications for their patients. There has been some confusion about these components of the AKF HIPP assistance among many, including social workers, who often assist patients in submitting their AKF HIPP applications. In recent weeks, we have seen clarifying documents come from AKF to help assist with this confusion, they can be accessed here http://www.kidneyfund.org/financial-assistance/information-for-patients/health-insurance-premium-program/#things_you_should_know_about_hipp. We have also spoken with the AKF leadership who has stated they will be providing additional clarity and educational opportunities about their program soon.

ESRD Patients Experiences with Choosing Health Insurance and Receiving Coverage

We surveyed dialysis patients and transplant recipients subscribed to NKF emails to better understand how they make insurance decisions and their experiences with their current insurance. In our survey we found that just over half of patients, under age 65 with ESRD, talked to someone about their insurance options. This help was most often provided by a social worker in the dialysis facility (72%), although about half also talked to someone else about their options (to include: insurance specialists from the dialysis facility; transplant social workers, coordinators or insurance specialists; other healthcare providers; and state health insurance programs).

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Further, among those seeking information from another source, 23% sought information from their private health insurance company. Of all patients that talked to someone about their health insurance options, 66% felt they understood all of their options.

In our survey we identified five dialysis patients who stated they were enrolled in Marketplace coverage. Three of those respondents stated they also had Medicare Part A and B. One of the respondents did not indicate they had any Medicare coverage, but indicated they had Medigap along with the Marketplace coverage. This same individual also stated they did not feel they understood all of their insurance options, despite having talked to a dialysis insurance coordinator and a dialysis social worker and seeking information independently. This individual did select that he/she is happy with the coverage and is receiving third party premium assistance, from a non-profit organization, which we presume is the American Kidney Fund. The individual also indicated they have to pay too much out of pocket for their dialysis treatments. We believe this individual is confused about the type of insurance they actually have. The remaining respondent who selected they had Marketplace coverage also selected that they did not talk to anyone about their coverage options, sought information through a government website, felt informed about their options, but was unhappy with their coverage because they had to pay too much out-of-pocket for all of their care and medications.

We did identify three additional respondents who indicated they had bought private coverage directly through an insurance company's website and were receiving third party premium assistance from a non-profit organization. All indicated they were happy with the coverage, but two also stated they have challenges with out-of-pocket costs and that they feel they would have to pay too much out-of-pocket to get a kidney transplant. All three had talked to a dialysis social worker and/or insurance specialist at the dialysis facility about their options and all three also stated they had sought information independently.

Insurer Practices

Insurers have been increasingly denying third party premium assistance payments for dialysis patients provided by the American Kidney Fund, going even as far to explicitly ask patients to attest that they are not directly receiving contributions from AKF to help pay their premiums. In addition, some plans also permit third-party premium assistance from other non-profit organizations, while singling out dialysis patients and excluding premium assistance provided by the American Kidney Fund. Over the past few years NKF has worked to end this and other discriminatory practices against ESRD patients by private insurers, particularly as it relates to Marketplace coverage. For example:

- In 2013 and 2014 insurance companies in Oregon and Washington required waiting periods for coverage of organ transplants if patients did not have prior insurance coverage. NKF contacted the state insurance commissioners and thankfully, Washington and Oregon passed regulations that prohibited this practice.
- We have seen and continue to see insurers in the Marketplace listing all immunosuppressive drugs, including generics, on the highest cost sharing tiers.

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- In 2015 and 2016 we have seen plans across several states that disclose if a person is eligible for Medicare due to ESRD they must enroll or the plan will only pay for services otherwise not covered by Medicare and will only pay secondary to Medicare three months after the patient begins dialysis or at the time they receive a transplant.
    - We have seen policies that disclose if a patient does not enroll in Medicare that the plan will only pay a certain percentage above the Medicare payment rate for dialysis services and that the patient may be balanced billed by the provider for charges above that rate, which will not be counted towards their out-of-pocket maximums.
    - We have even seen plans in which insurers state they will pay the Medicare premium for patients if they enroll in Medicare while also maintaining their private coverage with the carrier.
    - We have heard from patients and their social workers about instances where patients have been called by their insurance company and told they must enroll in Medicare.

A qualitative analysis of the open ended responses we received to our survey identified Medicare beneficiaries with Part A and B that had no supplemental coverage and indicated difficulty paying the 20% coinsurance. In some cases these beneficiaries indicated their coinsurance was waived by the dialysis company, but not by other providers. For some, this led to not seeking medical care beyond their dialysis facility. In addition, many respondents, including some respondents who have Medicare Part D, stated that they have high out-of-pocket costs for their prescription medications and were struggling to afford them. Additionally, some patients claimed they cannot afford to get a transplant. These respondents tended to be dually enrolled in Medicare and Medicaid or enrolled in Medicare without a supplemental policy. A few transplant recipients also indicated concerns about paying for private coverage when their Medicare ends 36 months after transplant or continuing to pay for their private insurance premiums when AKF HIPP assistances ends.

Recommendations to protect the rights of ESRD Patients

Responses to the survey questions are consistent with the types of questions and concerns we hear most often from dialysis patients who contact us. There appears to be some confusion around insurance options, which may lead patients to be more susceptible to steering by providers or insurers. **However, solutions to protect patients from steering should be focused on the providers and the insurers engaged in steering, not on limiting patients' access to choice in coverage or third party premium assistance provided by a non-profit organization with appropriate firewalls in place.** As a result NKF recommends the following:

1. NKF urges CMS affirmatively prohibit steering by both providers and insurers.

2. NKF urges CMS to differentiate steering from educating and require that when employees of healthcare companies are educating and assisting patients with their insurance options that they must educate patients on all options and the pros and cons of each option to ensure that patients

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are able to make informed, and independent, decisions about their insurance coverage.

3. CMS require that insurers accept third-party premium assistance from non-profit charitable organizations that meet specific firewalls, as the AKF HIPP program is required to do under the Office of Inspector General (OIG) Advisory Opinion.[10] Alternatively, and at a minimum, CMS should notify insurers that premium assistance from non-profits meeting these firewalls is allowable under Federal regulations as the ongoing practices of insurers indicate a misunderstanding that AKF's HIPP is indeed a permissible third-party premium assistance program offered by a charitable non-profit organization.

4. The Frequently Asked Questions (FAQs) Regarding Medicare and the Marketplace, originally issued August 1, 2014, be further updated with clarifying language related to ESRD patients' eligibility for Marketplace coverage and the implications of forgoing or delaying Medicare enrollment. We note the FAQs were updated April 28, 2016, but further clarifications are still needed. In September 2014, NKF joined the Medicare Rights Center and many other organizations in a letter requesting these FAQs be further refined. Some updates were provided. However, not all of clarifications we requested were made and we also note the response to question A3 is now incomplete and ends midsentence (page 5 of the April 28, 2016 updated FAQs). We request that CMS carefully review those joint recommendations (which we have included in the Appendix I of this letter) and make all of the further clarifying updates to the FAQs requested.

5. To enhance understanding by stakeholders, the FAQs be proactively distributed widely to all states' Departments of Insurance, Marketplace Administrators, health insurance companies, dialysis facilities, transplant centers, and State Health Insurance Programs. We also request that FAQs be incorporated into the training for Certified Application Counselors and Navigators as little to no information regarding ESRD patients and eligibility for Medicare and Marketplace coverage is provided in the training.

6. The interactions between Medicare and the Marketplace, particularly when it comes to ESRD patients, be addressed in formal guidance, such as the Notice of Benefits and Payment Parameters and applicable policy manuals, to further protect the rights of ESRD patients.

7. Healthcare providers and their staffs engaged in educating patients or counseling about insurance options be required to receive annual, independent education about health insurance options available to ESRD patients that includes a curriculum regarding the implications of those options. NKF would be happy to discuss recommendations for a curriculum with CMS should the agency pursue this solution.

[10] U.S. Department of Health and Human Services Office of the Inspector General Advisory Opinion No. 97-1.

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8. NKF agrees with the need for insurers to have balanced risk pools to ensure health insurance in the Marketplace is affordable. We recommend CMS proceed with improvements to the Risk Adjustment policy as it has proposed to do in the 2016 Notice of Benefits and Payment Parameters and that HHS continue to work to promote enrollment in the Marketplace to younger, healthy individuals.

9. NKF urges CMS to survey ESRD patients more broadly to understand their perception of the coverage choices, co-pay challenges, and access to care challenges they face. Ideally, the survey population would include beneficiaries treated with in-center hemodialysis, home hemodialysis, peritoneal dialysis and kidney transplantation. NKF would be pleased to partner with CMS to provide assistance in this regard.

NKF appreciates the opportunity to provide recommendations on how to better protect ESRD patients' rights and to provide clarity around those rights and the experiences patients have with their insurance coverage. We urge CMS to put the rights and interests of ESRD patients above health insurers and providers. Should CMS have further questions on this topic please contact Tonya Saffer, Senior Health Policy Director at 202.244.7900 ext. 717 or at tonya.saffer@kidney.org.

Sincerely,

Kevin Longino *Joseph Vassalotti*

Kevin Longino
CEO
Kidney Patient

Joseph Vassalotti, MD
CMO

Frequently Asked Questions Regarding Medicare and the Marketplace
August 1, 2014

This document is a compilation of the most frequently asked questions (FAQs) regarding the intersection of Medicare and the Marketplace. These FAQs have been cleared for use in response to public inquiries.

Please note that the frequently asked questions (FAQs) in this document apply specifically to those individuals who:

- have Medicare Part A only, Part B only, or neither, but who are seeking coverage through a Marketplace plan,
- had Marketplace coverage before becoming eligible for Medicare,
- have retained a Marketplace plan after enrolling in Medicare.

These FAQs do not apply to those individuals who have both Medicare Parts A & B and receive their health coverage exclusively through Medicare or a Medicare health plan.

The majority of individuals with Medicare coverage have both Medicare Parts A & B and do not have other private health insurance.

CMS added new FAQs to this document on April 28, 2016, in order to clarify the benefit coordination between Medicare and certain types of employer-based coverage. The new FAQs are D.7., D.8., and D.9.

Updated April 28, 2016

Frequently Asked Questions Regarding Medicare and the Marketplace
August 1, 2014

A. General Enrollment FAQs

A.1. Can individuals who have Medicare enroll in individual market coverage, such as coverage offered through the Individual Marketplace?

No. Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue an Individual Marketplace Qualified Health Plan (or an individual market policy outside the Marketplace) to a Medicare beneficiary. This prohibition does not apply in the SHOP market, or to employer coverage outside of the SHOP market.

A.2. Can Medicare beneficiaries whose employer purchases insurance coverage through the SHOP be enrolled in a SHOP Qualified Health Plan?

Yes, Medicare beneficiaries whose employers purchase SHOP coverage are treated the same as any other person with employer Group Health Plan coverage. The statute (Section 1882(d) of the Social Security Act) prohibits the sale or issuance of duplicate coverage to an individual with Medicare, but employer-sponsored coverage is explicitly exempted from this prohibition. SHOP coverage is sold to the employer. Note that for Medicare beneficiaries who are active employees and are enrolled in SHOP coverage, the Medicare Secondary Payer rules, which govern the coordination of benefits between Medicare and the employer coverage, apply to employers with 20 or more employees.

A.3. Does the prohibition against the sale or issuance of duplicate coverage to an individual with Medicare apply to selling or issuing coverage to someone eligible for Medicare but not yet signed up?

No. The prohibition, set forth in Section 1882(d) of the Social Security Act, applies to selling or issuing coverage to someone who has Medicare Part A or Part B. However, the regulations at 26 CFR §1.36B-2(c)(i) state that an individual who is eligible to receive benefits under government-sponsored minimum essential coverage (e.g. Medicare Part

A.4. Do beneficiaries with Part B only meet the Affordable Care Act's requirement to maintain Minimum Essential Coverage?

Medicare Part B alone does not constitute Minimum Essential Coverage.

A.5. Does it make any difference to the Affordable Care Act's requirement to maintain Minimum Essential Coverage if an individual with Part B only is required to pay the Income Related Monthly Adjustment Amount for Part B?

No, the same principles apply.

A.6. The Individual Marketplace Qualified Health Plans (QHPs) may be cheaper than Medicare for individuals who have to pay a premium for Part A. Can someone with Premium Part A drop Medicare and enroll in the Individual Marketplace?

Yes. Individuals who are not eligible to get Medicare Part A for free may drop both their Premium Part A and their Part B coverage (or choose not to enroll when first eligible). An individual who does not have Medicare (either Part A or Part B) can enroll in a QHP.

Note that individuals who get free Part A cannot drop it without dropping their retiree benefits (social security or railroad retirement) and paying back all retirement benefits received and costs incurred by the Medicare program as well.

Before making this choice, there are 2 important points for individuals to consider:

- Individuals who do not enroll in Medicare when first eligible (during their initial enrollment period) may have to pay late enrollment penalties if they later apply for both Premium Part A and Part B. The Part B penalty applies for as long as the individual has Part B coverage.
- In addition, individuals who enroll in Medicare after their initial enrollment period ends can enroll in Medicare only during the Medicare general enrollment period (from January 1 to March 31) and coverage does not begin until July of that year.

A.7. Can a Medicare beneficiary purchase a stand-alone dental plan through the Individual Marketplace?

Even though Medicare does not provide dental coverage, and therefore a stand-alone dental plan would not duplicate Medicare benefits, the Federally-facilitated Marketplaces (FFMs) require that individuals buy a comprehensive medical Qualified Health Plan (QHP) before they can purchase a separate dental plan. Because it is illegal to sell or issue a comprehensive medical QHP to a Medicare beneficiary, Medicare beneficiaries cannot currently buy a stand-alone dental plan through the FFMs. Nothing in federal law prohibits issuers from generally selling or issuing stand-alone dental plans through State Based Marketplaces that can support this functionality, or outside the Marketplaces, to Medicare beneficiaries.

A.8. If you have coverage in an Individual Marketplace Qualified Health Plan (QHP) and later enroll in Medicare, can you keep your Marketplace coverage?

Yes. The prohibition on selling or issuing duplicative coverage set forth in Section 1882(d) of the Social Security Act applies to the sale or issuance of a (QHP) or other individual market coverage to a Medicare beneficiary. It does not require an individual who was not a Medicare beneficiary when the QHP was purchased to drop coverage when he or she becomes a Medicare beneficiary.
Once Medicare Part A coverage begins, however, any premium tax credits and reduced cost-sharing the individual receives through the Marketplace will be discontinued.
See the chart below for details.

Chart A: Maintaining Enrollment in an Individual Marketplace Qualified Health Plan (QHP) Once Medicare Coverage Begins

If you are:	Can you keep your Individual Marketplace QHP after enrolling in Medicare?	Are you eligible to continue receiving tax credits and reduced cost-sharing?
Currently enrolled in a QHP and become entitled to free Part A	Yes	No. Any tax credits the individual is receiving in the QHP will be discontinued once Part A coverage begins.
Currently enrolled in a QHP and become eligible to buy Premium Part A and Part B	Yes	Yes, if you only enroll in Part B, because Part B does not constitute Minimum Essential Coverage. No, if you enroll in Premium Part A.

A.9. Will individuals enrolled in an Individual Marketplace Qualified Health Plan (QHP) be subject to the Part B or Premium Part A late enrollment penalty if they delay enrollment into Medicare?

Yes. Individuals who do not enroll in Medicare during their Initial Enrollment Period (either for Part B or Premium Part A) will only be able to enroll in Medicare during the Medicare General Enrollment Period and may be subject to the late enrollment penalties. The Part B penalty applies for as long as the individual has Part B.

A.10. Can Medicare beneficiaries with coverage under SHOP plans delay enrollment in Medicare Part B without penalty?

Yes. A Medicare beneficiary who is enrolled in employer purchased SHOP coverage is treated the same as any other person with employer group health plan coverage. Individuals can delay enrollment if they are covered under a group health plan based on their or their spouse's current employment. These individuals have a special enrollment period to sign up for Part B without penalty:

- Any time they are still covered by the group health plan.
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first.

If the individual does not sign up during this special enrollment period, enrollment will only be possible during the General Enrollment Period which occurs annually from January through March with coverage beginning July 1. The individual may also have to pay a late enrollment penalty for as long as he or she has Part B.

A.11. Is prescription drug coverage in an Individual Marketplace or SHOP Qualified Health Plan (QHP) considered creditable prescription drug coverage for purposes of Medicare Part D?

While prescription drug coverage is an essential health benefit, there is no requirement under the Affordable Care Act or its implementing regulations that prescription drug coverage in an Individual Marketplace or SHOP QHP be at least as good as Medicare Part D coverage, which is the general test for whether coverage is creditable. However, all private insurers offering prescription drug coverage, including Individual Marketplace and SHOP QHPs, are required to determine annually if their prescription drug coverage is creditable and notify CMS and their Medicare-eligible enrollees in writing of the determination.

All private insurers offering prescription drug coverage are required to notify their Medicare-eligible enrollees of the plan's creditable coverage status in writing annually prior to the start of the Medicare open enrollment period that begins on October 15, and in the following situations:

- Prior to an individual's Initial Enrollment Period for Part D;
- Prior to the effective date of enrollment in the insurer's prescription drug coverage;
- Upon any change that affects whether the coverage is creditable; and
- Upon request by the individual.

A.12. Is prescription drug coverage through the Marketplace considered creditable prescription drug coverage for the purposes of determining whether an individual must pay the late enrollment penalty upon enrollment in Medicare Part D?

While prescription drug coverage is an essential health benefit, prescription drug coverage in a Marketplace or SHOP plan isn't required to be expected to pay, on average, at least as much as Medicare's standard prescription drug coverage (creditable). All private plans offering prescription drug coverage, including Marketplace and SHOP plans, must determine if their prescription drug coverage is creditable each year and let you know in writing.

A.13. If a person is enrolled in Part A and has chosen not to enroll in Part B, can that person purchase a QHP (or other individual market coverage) until their Part B is effective?

For beneficiaries who would purchase their plan on the individual market, no. Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal for an insurer to sell or issue to a Medicare beneficiary a QHP (or other individual market coverage) that the insurer knows would duplicate Medicare benefits. This is true even if the beneficiary has only Part A or only Part B.

This prohibition does not apply in the small group market, including plans sold through the Small Business Health Options Program (SHOP). Medicare beneficiaries whose

employers purchase SHOP coverage are treated the same as any other person with employer-sponsored Group Health Plan (GHP) coverage. The statute (Section 1882(d) of the Social Security Act) prohibits the sale or issuance of coverage that the insurer knows duplicates Medicare benefits to an individual with Medicare, but employer-sponsored (GHP) coverage is explicitly exempted from this prohibition. SHOP coverage is sold to the employer. Note that for Medicare beneficiaries who are active employees and are enrolled in SHOP coverage, the Medicare Secondary Payer rules govern the coordination of benefits between Medicare and the employer coverage as appropriate.

A.14. If an individual is over age 65 and eligible for premium-free Part A, but is not collecting Social Security benefits and has not enrolled in either Part A or Part B, can that person purchase a QHP (or other individual market coverage)?

Yes. If the individual is not collecting Social Security benefits, and is not covered by Medicare (that is, he or she does not have either Part A or Part B), then the anti-duplication statute in section 1882(d) of the Social Security Act would not prohibit the issuer of a QHP (or other individual market coverage) from issuing or selling coverage to the individual. Please note, not enrolling in Part B when an individual is first eligible may result in paying late enrollment penalties. The Part B late enrollment penalty applies for as long as the individual has Part B.

A.15. Is purchasing a QHP (or other individual market plan), instead of enrolling in Medicare Part B, an option for individuals who fail to enroll in Part B in a timely manner and must pay a Part B premium penalty, especially in those situations where the higher premium resulting from the penalty may be more than the individual would pay for a QHP—with or without a tax credit?

Generally, no. If an individual already has Medicare coverage (including Part A and/or Part B coverage), consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal for an insurer to knowingly sell or issue to a Medicare beneficiary an individual market plan that the insurer knows would duplicate Medicare benefits, regardless of the cost of the Part B premium amount. An individual who does not have Medicare (neither Part A nor Part B) and who is otherwise eligible can enroll in a QHP.

An individual who does not enroll in Medicare during his or her Medicare Initial Enrollment Period (either for Part B or Premium Part A) will only be able to enroll in Medicare during the Medicare General Enrollment Period. In addition, if the individual chooses to enroll later, he or she may be subject to late enrollment penalties. The Part B late enrollment penalty applies for as long as the individual has Part B.

A.16. A Qualified Health Plan (QHP) may be cheaper than Medicare for individuals who get Part A for free but have to pay a late enrollment penalty or Income-Related Monthly

Adjustment Amount (IRMAA) for Part B. Can someone with free Part A drop Medicare and enroll in a QHP?

Generally, no. Individuals generally can choose to stop Medicare coverage only if they're paying a premium for Part A or have only Part B. Individuals with free Part A can't drop Medicare without also dropping their retiree benefits (Social Security or Railroad retirement) and paying back all retirement or disability benefits they received and all costs spent for their care by the Medicare program.

Before making this choice, there are two important points for individuals to consider: An individual who does not enroll in Medicare during his or her Medicare Initial Enrollment Period (either for Part B or Premium Part A) will only be able to enroll in Medicare during the Medicare General Enrollment Period. The General Enrollment Period occurs from January 1 to March 31 with coverage beginning on July 1 of that year. In addition, if the individual chooses to enroll later, he or she may be subject to late enrollment penalties. The Part B late enrollment penalty applies for as long as the individual has Part B.

B. ESRD

B.1. Are Individuals with ESRD required to sign up for Medicare?

No. Individuals with ESRD are not required to sign up for Medicare; it is voluntary. In order to get Medicare coverage, the individual must meet the necessary eligibility requirement and apply. If you don't apply, you do not get Medicare coverage.

B.2. Are individuals with ESRD who do not have Medicare coverage eligible to enroll in a Marketplace Qualified Health Plan (QHP)?

Individuals with ESRD who do not have either Medicare Part A or Part B are eligible to enroll in individual market coverage because the Medicare anti-duplication statute does not apply; therefore, individual market guaranteed issue rights apply under the ACA. In order to enroll in a QHP through the Marketplace, the individual must meet the eligibility requirements for enrollment (i.e., criteria related to citizenship, lawful presence, incarceration, and residency).

B.3. Are individuals with ESRD who do not have Medicare coverage eligible for the health care Premium Tax Credit?

An individual may be eligible for the health care Premium Tax Credit if he or she is not eligible for minimum essential coverage, as outlined in the IRS Notice 2013-41 at the following web link: http://www.irs.gov/pub/irs-drop/n-13-41.pdf

However, individuals will lose their eligibility for the health care Premium Tax Credit when coverage in Medicare Part A begins.

B.4. Can beneficiaries who currently have Medicare coverage due to ESRD opt out of or disenroll from Medicare?

Generally, no. Following the application for Medicare, the law provides that Medicare coverage ends one year after the termination of regular dialysis or 36 months after a successful kidney transplant. However, a beneficiary may withdraw their original Medicare application. The individual is required to repay all costs covered by Medicare, pay any outstanding balances, and refund any benefits received from the SSA or RRB. Once all repayments have been made, the withdrawal can be processed as though the individual was never enrolled in Medicare at all (i.e., retroactively).

B.5. Is there a mechanism for individuals to cancel ESRD Medicare enrollment if applications are initiated on their behalf without complete information about their options for QHPs?

A dialysis facility or attending physician may not complete an application for Medicare entitlement on behalf of the beneficiary. While these providers may submit the medical evidence form for an individual applying for Medicare based on ESRD, the individual must also contact the Social Security Administration (SSA) to complete the Medicare application.

If an individual wants to enroll in a QHP after the medical evidence form is submitted by the provider, the individual can choose to not complete his or her application for Medicare. If the individual has Medicare currently based on ESRD, he or she may withdraw their original Medicare application. The individual is required to repay all costs covered by Medicare, pay any outstanding balances, and refund any benefits received from the SSA or RRB. Once all repayments have been made, the withdrawal can be processed as though the individual was never enrolled in Medicare at all (i.e., retroactively).

B.6. Please clarify whether individuals with ESRD who are currently enrolled in Medicare based on ESRD can disenroll from both Part A and Part B. If yes, please specify the requirements for doing so and the potential ramifications of this choice.

Generally, individuals with ESRD who are currently enrolled in Medicare based on ESRD cannot disenroll prospectively. Following the application for Medicare, the law provides that Medicare coverage ends one year after the termination of regular dialysis or 36 months after a successful kidney transplant. However, a beneficiary may withdraw their original Medicare application. The individual is required to repay all costs covered by Medicare, pay any outstanding balances, and refund any benefits received from the SSA or RRB. Once all repayments have been made, the withdrawal can be processed as though the individual was never enrolled in Medicare at all (i.e., retroactively).

C. Consumer Messaging

C.1. What is the message to Medicare beneficiaries who have questions about how the Marketplace affects them?

Medicare isn't part of the Health Insurance Marketplace. If you have Medicare, you are covered, and do not need to do anything about the Marketplace.
The Marketplace won't affect your Medicare choices and benefits. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan, you won't have to make any changes.

C.2. What do Medicare beneficiaries need to know about Medicare and the Individual Marketplace?

Individuals with Medicare need to know that if they have Medicare, an Individual Marketplace plan is not appropriate for them. If individuals want coverage designed to supplement Medicare, they can visit Medicare.gov to learn more about Medigap policies. They can also visit Medicare.gov to learn more about other Medicare options, like Medicare Advantage Plans.

C.3. I want to purchase health insurance through the Marketplace. What if I have Medicare?

Medicare isn't part of the Health Insurance Marketplace, so you don't need to do anything. If you have Medicare, you're considered covered. The Marketplace won't affect your Medicare choices or benefits. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO), you won't have to make any changes. Note: The Marketplace doesn't offer Medicare supplement (Medigap) insurance or Part D drug plans.

C.4. Can I get a Marketplace plan if I already have Medicare?

No. It's against the law for someone who knows that you have Medicare to sell or issue you a Marketplace policy. This is true even if you have only Medicare Part A or only Part B. If you want coverage designed to supplement Medicare, you can find out more about Medigap policies. You can also learn about other Medicare options, like Medicare Advantage Plans. For prescription drug coverage, you can buy a Medicare Part D drug plan.

C.5. Can I choose Marketplace coverage instead of Medicare?

Generally, no. It's against the law for someone who knows you have Medicare to sell you a Marketplace plan. But there are a few situations where you can choose a Marketplace private health plan instead of Medicare:

- If you're paying a premium for Part A. In this case you can drop your Part A and Part B coverage and get a Marketplace plan instead.
- If you're eligible for Medicare but haven't enrolled in it. This could be because:
    - You'd have to pay a premium

- You have a medical condition that qualifies you for Medicare, like end-stage renal disease (ESRD), but haven't applied for Medicare coverage
- You're not collecting Social Security retirement or disability benefits before you're eligible for Medicare

Before choosing a Marketplace plan over Medicare, there are 2 important points to consider:

- If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare.
- Generally you can enroll in Medicare only during the Medicare general enrollment period (from January 1 to March 31 each year). Your coverage won't start until July. This may cause a gap in your coverage.

C.6. If I'm getting Medicare Part A for free, can I drop Medicare to enroll in a Marketplace plan?

Generally, no. You can choose to have your Medicare stop only if you're paying a premium for Part A or have only Part B. If you get Part A for free, you can't drop Medicare without also dropping your retiree or disability benefits (Social Security or railroad retirement) and paying back all retirement or disability benefits you've received and all costs spent for your care by the Medicare program. Before making this choice, there are 2 important points to consider:

- If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare.
- Generally you can enroll in Medicare only during the Medicare general enrollment period (from January 1 to March 31 each year). Your coverage won't start until July. This may cause a gap in your coverage.

C.7. I have coverage through an Individual Marketplace Qualified Health Plan (QHP) and then I enroll in Medicare. Once my coverage in Medicare starts, can the QHP disenroll me without my consent?

No, issuers may not terminate enrollees whom they subsequently find to be eligible for or enrolled in Medicare, unless the enrollee requests the termination.

C.8. Can an individual market health insurance issuer disenroll someone if it learns that individual is a Medicare beneficiary prior to the individual's coverage effective date?

Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue an Individual Marketplace Qualified Health Plan (or an individual market policy outside the Marketplace) to a Medicare beneficiary. The issuer should cancel an enrollment prior to the policy being issued if the issuer learns that the enrollment is for someone who has Medicare coverage. That is, the start date for the individual's Part A and/or Part B was before the effective date of the individual market coverage. However, if the applicant's Medicare coverage has not started yet, then the issuer issue the coverage on a guaranteed available basis.

Issuers may not, however, terminate the individual market coverage of enrollees who they find to be eligible for or enrolled in Medicare after the coverage has been issued, even if the individual was eligible for or enrolled in Medicare before enrollment into the individual market coverage, unless the enrollee requests the termination or another legal basis for termination applies.

C.9. What if I have only Medicare Part B?

If you have only Medicare Part B, you are not considered to have minimum essential coverage. This means you may have to pay the penalty that people who don't have coverage may have to pay. If you have Medicare Part A only, you are considered covered. If you have both Medicare Part A and Part B, you are also considered covered.

C.10. What if I have a Marketplace plan but will be eligible for Medicare soon?

If you have a Marketplace plan, you can keep it until your Medicare coverage starts. Then you can cancel it without penalty. If you like, you can keep your Marketplace plan too. But if you've been getting tax credits or lower out-of-pocket costs on a plan you bought through the Marketplace, these savings will end once your Medicare Part A coverage starts. You'd have to pay full price for the Marketplace plan.

Let's assume you have a Marketplace plan and are turning 65 sometime this year. Once you're eligible for Medicare, you'll have an initial enrollment period to sign up for Medicare. For most people, the initial enrollment period starts 3 months before their 65th birthday and ends 3 months after their 65th birthday. In most cases it's to your advantage to sign up for Medicare when you're first eligible because:

- Once your Medicare Part A coverage starts, you won't be able to keep any premium tax credits or lower out of pocket costs for a Marketplace plan based on your income. You'll have to pay full price for the Marketplace plan.
- If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare. In addition, you can enroll in Medicare Part B (and Part A if you have to pay a premium for it) only during the Medicare general enrollment period (from January 1 to March 31 each year). Coverage doesn't start until July of that year. This may create a gap in your coverage.

If you want coverage to supplement Medicare, you can get Medicare supplement (Medigap) insurance. For prescription drug coverage, you can buy a Medicare Part D drug plan. You can learn about other Medicare options, like Medicare Advantage Plans.

Once your Medicare coverage starts, you can cancel your Marketplace health plan without penalty. You can do this by contacting the Marketplace call center or cancelling your coverage online. If you have Medicare coverage, you're considered covered under the health care law. You won't have to pay the fee that some people without insurance must pay. Be sure not to cancel your Marketplace plan before your Medicare coverage begins. Otherwise you may have a gap in coverage.

C.11. Medicare beneficiaries under age 65 don't have federal guaranteed issue rights to purchase Medicare Supplement (Medigap) insurance coverage. Can these beneficiaries enroll in the Individual Marketplace to supplement their Medicare coverage?

No, consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue a Qualified Health Plan (QHP) to a Medicare beneficiary. If individuals are seeking supplemental coverage for their Medicare, and do not have retiree coverage, they should consult Medicare.gov about enrolling in a Medicare Advantage plan, or check with their State department of insurance to see if their state requires the sale of Medigap policies to people under age 65.

D. Coordination of Benefits Policy

D.1. If someone is enrolled in both Medicare and an Individual Marketplace Qualified Health Plan (QHP), will there be coordination of benefits?

If someone is enrolled in both Medicare and an Individual Marketplace QHP, Medicare is the primary payer. Medicare does not provide coordination of benefits.

D.2. Will Coordination of Benefits apply to someone who is enrolled in Medicare and a SHOP Qualified Health Plan (QHP)?

Medicare beneficiaries whose employer purchases SHOP coverage are treated the same as any other person with employer coverage. If the employer has 20 or more employees, the employer-provided health coverage generally will be primary for a Medicare beneficiary who is covered through active employment.

D.3. What do employers participating in SHOP need to know about the Medicare Secondary Payer rules?

An employer participating in SHOP will be impacted by the Medicare Secondary Payer (MSP) rules if the employer has 20 or more employees, and any of its employees are Medicare beneficiaries. When offering health coverage to its employees, the employer cannot "take Medicare into account" when determining if an individual is eligible for enrollment in the employer-sponsored plan. This means that the employer can't exclude the individual's opportunity to participate in the employer-sponsored Group Health Plan coverage on the basis that the employee is a Medicare beneficiary.

D.4. What do SHOP Qualified Health Plans (QHPs) need to know about the Medicare Secondary Payer rules?

If the employer has 20 or more employees, the SHOP QHP insurer will be required to participate in the Medicare program's "Section 111 Group Health Plan Reporting" program, which is mandated by applicable Medicare Secondary Payer (MSP) regulations. Insurers under these circumstances will be required to register with CMS' Medicare Secondary Payer Coordination of Benefits Contractor and report its coverage of the working people with Medicare to CMS under the MSP reporting requirements.

D.5. Will SHOP plans be required to inform beneficiaries of any benefit coordination?

Yes. SHOP insurers are required to notify their enrollees of the coordination of benefits between Medicare and the employer coverage.

D.6. Will Marketplace coverage purchased prior to an individual enrolled in and/or entitled to Medicare affect that individual's eligibility for the Medicare Part D Low-Income Subsidy (LIS) program?

Having Marketplace coverage is not a factor in determining whether or a beneficiary is eligible for the Low-Income Subsidy (LIS) program.

D.7. An individual is enrolled in health insurance coverage based on active employment through an employer that is defined (for purposes of the Affordable Care Act market reforms) as small (including SHOP coverage) and is eligible for Medicare due to turning 65 but isn't enrolled in Medicare. Can the small group health plan change the payment level for or refuse to pay for covered services for which Medicare would have paid had the person been enrolled in Medicare?

No. In the absence of other primary coverage (such as Medicare), a SHOP QHP (or other non-grandfathered, small group market coverage) is expected to pay for covered services as the primary payer. Per the essential health benefits and actuarial value requirements under the Affordable Care Act, a small group market insurance plan may not limit coverage based on the theoretical possibility of an individual's enrollment in other coverage. Additionally, modifying a benefit design based on Medicare eligibility could be considered discriminatory in violation of the federal non-discrimination prohibitions.[1] As such, a SHOP QHP or other non-grandfathered small group health plan must pay for services for an enrollee who is eligible for but not enrolled in other primary coverage as if the enrollee were not eligible for such coverage.

EXAMPLE: Ms. Lee is still working and has SHOP coverage through her employer. She turns 65 and becomes eligible to get Medicare, but she has not enrolled in Medicare. She sees a health care provider for a service that the SHOP plan covers and that Medicare would have covered as well. The provider charges $150 for the service. Medicare does not pay anything since Ms. Lee has not enrolled in Medicare. The health plan's contract indicates that Ms. Lee has a $30 copay for this service. The health plan is responsible for $120 and Ms. Lee is responsible for her $30 copay.

D.8. An individual is enrolled in employer group "retiree only" coverage and is eligible for but isn't enrolled in Medicare. Can the group retiree health plan change the payment level for or refuse to pay for covered services for which Medicare would have paid as the primary payer had the person been enrolled in Medicare?

Yes, if the retiree coverage has a contractual stipulation that allows the plan to pay at a different rate (or not at all), as long as Medicare would have been primary. Retiree coverage is exempt from the market reforms implemented under the Affordable Care Act,

[1] Non-discrimination provisions that may apply to non-grandfathered small group health insurance coverage include those in the guaranteed availability regulation (45 CFR 147.104(e)); the essential health benefits regulations (45 CFR 156.125); and the QHP certification standards (45 CFR 156.200(e)), as applicable.

including the essential health benefits and actuarial value requirements and the non-discrimination provision at 45 CFR §147.104(e). Therefore, the ACA market reforms do not prohibit retiree-only plans[2] from paying at a different rate or not at all if a member becomes eligible for other insurance coverage that would have paid as primary, even if the member chooses not to enroll in the other coverage. MSP rules do not apply to retirees who do not have current employment status.

EXAMPLE: Ms. Casserly has retiree-only coverage through her former employer. She turns 65 and becomes eligible to get Medicare, but she has not enrolled in Medicare. She sees her health care provider for a service that her retiree insurance covers and that Medicare would have covered as well. The health care provider charges $150 for the service. Medicare doesn't pay anything since Ms. Casserly has not enrolled in Medicare. The retiree health plan's contract indicates that Ms. Casserly has a $20 copay for this service. However, it also indicates that if Ms. Casserly becomes eligible for other coverage (whether she enrolls in it or not), the plan will pay at a lesser rate. In this case, the retiree health plan's contract says it will only pay 50% of the fee leaving Ms. Casserly with a $75 cost-sharing obligation.

D.9. An individual who receives coverage through his employer's self-insured group health plan for active employees is eligible for Medicare due to turning age 65 but is not enrolled in Medicare. The employer has fewer than twenty employees. Can the employer change the payment level for or refuse to pay for otherwise covered services for which Medicare would have paid as the primary payer had the individual been enrolled in Medicare?

Yes, if the employer's group health plan contractual terms allow the employer to pay at a different rate (or not at all) and Medicare would have been primary (i.e., when the employer has fewer than twenty employees). A self-insured group health plan offered by an employer is not subject to the essential health benefits and actuarial value requirements or various non-discrimination provisions of the Affordable Care Act and its implementing regulations. As such, those ACA requirements do not prohibit an employer health plan from paying at a different rate or not at all if a member becomes eligible for other coverage that would have paid as primary to the employer, even if the member chooses not to take that other coverage.

EXAMPLE: Mr. Ludwig has coverage through his employer. His employer has fewer than twenty employees. He turns 65 and becomes eligible to get Medicare, but he hasn't enrolled in Medicare. He sees his health care provider for a service the employer's contract covers and that Medicare would have covered as well. The health care provider charges $150 for the service. Medicare doesn't pay anything since Mr. Ludwig doesn't have Medicare. The self-insured employer's contract indicates that Mr. Ludwig has a $30 copay for this service. However, it also indicates that in the event Mr. Ludwig becomes eligible for other coverage (whether he enrolls in it or not), the employer will pay at a

[2] See FAQ dated October 12, 2010 which addresses the exemption from the Affordable Care Act for group health plans with less than 2 current employees, which can be found here: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html.

lesser rate. In this case, the terms of the employer's plan says it will only pay 20% of the fee leaving Mr. Ludwig with a $120 cost-sharing obligation.

E. Enrollment Operations

E.1. Does the FFM application screen for Medicare enrollment?

The FFM application verifies enrollment in Medicare for individuals who have requested financial assistance. However, the FFM systems are not currently set up to prevent Medicare beneficiaries from enrolling in a Qualified Health Plan.

E.2. Will the Marketplace add a note to the Individual Marketplace paper application telling people not to apply if they have Medicare?

Specific Medicare messaging isn't included in the online or paper applications; however, in the 2014 Medicare & You Handbook, the Medicare call center, Medicare.gov, and HealthCare.gov, we have reassured beneficiaries that they are covered, their Medicare benefits aren't changing, and the Marketplace doesn't require them to do anything differently. In our public messaging, individuals are informed that Medicare isn't part of the Health Insurance Marketplace. If you have Medicare, you are covered, and do not need to explore coverage through the Marketplace. The Marketplace won't affect your Medicare choices, and your benefits won't be changing. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan, you'll still have the same benefits and security you have now. You won't have to make any changes.

Appendix II : Survey Details

We issued the survey to 40,000 patients we had identified in our database who were subscribed to receive NKF communications and who indicated they had ESRD. Given the time limitations we allowed 6 days for responses, but were unable to conduct follow up to achieve a higher response rate. We received 623 responses, a 1.6% response rate. A little less than half (307) of the respondents were under age 65. The following survey questions were asked:

1. Are you a dialysis patient?

- ◯ Yes
- ◯

2. Are you a kidney transplant recipient?

- ◯ Yes
- ◯ No

3. Were you on dialysis prior to your transplant?

- ◯ Yes
- ◯ No

4. How old are you?

- ◯ Under 65
- ◯ Over 65

5. When you became aware of your need for dialysis or a kidney transplant did someone talk to you about your health insurance options?

- ◯ Yes
- ◯ No

6. Who talked to you about your health insurance options (check all that apply)?

- [ ] Dialysis social worker
- [ ] Dialysis insurance specialist
- [ ] Transplant social worker or coordinator
- [ ] Transplant insurance specialist
- [ ] Other healthcare professional
- [ ] State Health Insurance Program
- [ ] Other person or entity (please specify, but do not identify someone by name)

7. Did you seek out any information about insurance options on your own?

- [ ] Yes
- [ ] No

8. Where did you find information about health insurance options for kidney patients (check all that apply)?

- [ ] A non-profit organization dedicated to helping kidney patients
- [ ] A government website
- [ ] My private insurance company

Other (please specify, but do not identify an individual person by name)

9. Did you feel that you understood all health insurance options available to you?

- Yes
- No

10. Do you have Private/Commercial health insurance coverage?

- Yes
- No

11. What type of private health insurance do you have?

- I have insurance through my employer or my spouse's employer (employee group health plan)
- I bought a private plan directly through an insurance provider
- I bought an private plan through the Affordable Care Act exchange/marketplace (Obamacare)

12. Do you have any other health insurance?

- Yes
- No

13. What type of insurance coverage do you have (check all that apply).

- [ ] Medicare Part A
- [ ] Medicare Part B
- [ ] Medicare Part D
- [ ] My Medicare benefits are through an insurance company, for example, Aetna, AARP/United, Humana (Medicare Advantage, Part C)
- [ ] Medicare Supplement (Mediap)
- [ ] Medicaid
- [ ] Department of Veterans Affair or Tricare
- [ ] I don't have any health insurance
- [ ] I do not know what health insurance I have
- [ ] Other insurance (please specify)

14. Have you ever received financial assistance to help pay for your health insurance or does another organization pay your health insurance premiums on your behalf?

- ( ) Yes, I am currently getting help to pay for my insurance premiums
- ( ) Yes, I used to get help paying for my insurance premiums
- ( ) No, I have never received help to pay for my insurance premiums

15. Which of the following organizations or programs helped you pay for your insurance premiums or provided you financial assistance? (check all that apply)

- [ ] State or Federal Government
- [ ] Non-profit kidney organization
- [ ] Health Care Provider
- [ ] I receive tax credits from my Affordable Care Act (health exchange/Obamacare) plan
- [ ] I am enrolled in a Medicare Savings Program
- [ ] I receive "Extra Help" on my prescriptions through Social Security

Other (please specify)

16. Are you happy with your choice of insurance?

- ◯ Yes
- ◯ No

Tell us more here:

17. What are the greatest challenges you face in accessing health care under your current insurance (check all that apply)?

- [ ] Have to pay too much out of my own pocket for prescription medications
- [ ] Have to pay too much out of my own pocket to visit the doctor
- [ ] Have to pay too much out of my own pocket for dialysis treatments
- [ ] Have to pay too much out of my own pocket to be considered for a transplant
- [ ] Have to pay too much out of my own pocket when I need to go to the hospital or emergency department
- [ ] I have difficulty finding healthcare providers who take my insurance
- [ ] I have no difficulty getting the care I need
- [ ] Other (please specify)

18. Did you ever need to change insurance plans? If so why?

- ( ) No I have never changed plans
- ( ) Yes, I was not happy with my original choice
- ( ) Yes, my coverage was canceled
- ( ) Yes, Other - Please explain:

19. Was it hard to change your insurance plan? If so what difficulties did you face?

- ( ) No, it was not hard for me to change insurance plans.
- ( ) Yes, I was uninsured during the waiting period before my new coverage started.
- ( ) Yes, I was charged a late enrollment penalty.
- ( ) Other (please specify)

20. Have you experienced challenges in getting a kidney transplant because of your health insurance?

- ◯ No
- ◯ Yes. Please describe the challenges:

21. In the past 5 years, have you ever been denied health insurance or dropped from coverage?

- ◯ No
- ◯ Yes. Please explain why?

22. Is there anything else you would like to tell us about your experience with health insurance?